**State of South Dakota**
**Office of Procurement Management**
**RFP #2431 – Department of Social Services (DSS)**
**Health Home Quality Assurance Review**
**Due Thursday, September 30th by 5:00pm CDT**

## QUESTIONS/ANSWERS

Please note that similar questions were combined so you may not see yours exactly as written.

1. Is there an incumbent contractor providing these services to DSS?

   *No, the work was previously completed using state staff.*

2. Section 3.0 on pg. 7, the RFP states the offeror should propose one or more methodologies to be used to conduct quality assurance review(s). Is it expected that the offeror complete quality assurance reviews to validate that the Health Home was eligible to receive the Per Member/Per Month (PMPM) payment, the annual supplemental quality incentive payment received or both?

   *The goal of the Quality Assurance Review is to ensure that Health Homes meet key items as required by the Health Home Program. Section 1.1.2 indicates the items that SD has reviewed in the past. An additional item that should be considered is the movement of several measures to the Care Plan instead of having them submit as part of the data set. These items can be found at https://dss.sd.gov/docs/healthhome/outcomemeasures/2021_Items_for_the_Care_Plan.pdf . The provision of the Core Service is another item. Respondent should review the SPA for the Health Home program to identify other items that should be reviewed, propose items to be reviewed as part of their response.*

   Do we want them also to review the providers response to each of the outcome measures?

   *This was not anticipated within the scope of the RFP, should an offeror wish to discuss this as part of their methodology, the offeror should describe and bid it separately.*

3. Section 1.1.2 on pg. 3, states that DSS estimates the reviews for 2021 will encompass 137 clinics. Since the RFP contemplates a three-year contract:

   a. Are there also estimates for the volume per tier for 2021?

      *Taking only those recipients with a core service provided and deduplicated on recipient number and Tier. DSS estimates that the volume for 2021 will be Tier 1 – 146, Tier 2 – 5424, Tier 3 - 3420, Tier 4-1418*

b. Are there estimates available for the number of clinics to be reviewed in 2022?

*The 2020 review encompassed 132 clinics and DSS estimates that 2021 will encompass 137 clinics. Typically, the SD Health Home Program enrolls around 3 -4 new clinics per year.*

c. Are there expectations that the number of participants or clinics will change in 2023 and 2024?

*When the Public Health Emergency (PHE) expires enrollment is expected to decrease. Contingent on the expiration of the PHE, DSS expects the number of recipients to decline for years 2022-2024.*

*See item b for the possible number of new clinics.*

4. Section 1.1.2 pg. 3, states the sample size for the 2020 review was 446.Will the successful offeror need to provide a statistically valid sample and extrapolate findings?

   *Offerors should provide their recommended methodology, which DSS would anticipate likely including a statistically valid sample with extrapolated findings.*

   Can DSS also provide information describing the methodology used to derive the 2020 sample size of 446?

   *See 1.1.2 Current Methodology to answer how we derived at the sample used for 2020.*

5. If adverse findings are determined because of the quality assurance review activities, is the offeror responsible for identifying, tracking, and supporting recovery of any overpayments that may occur?

   *The offeror will be responsible for drafting a summary letter for each clinic and providing a report to DSS that identify the concerns. Offeror will need to provide a list of recipients where a core services was claimed, but none was identified. DSS will handle the recovery of payment the PMPM.*

6. Will the offeror be responsible to support appeals of quality assurance review findings?

   *Providers should have an option to discuss the results of the review with the offeror prior to the release of results to the state.*

7. Can DSS please provide the historical average number of days between the initiation of a quality assurance review and the conclusion of that review?

   *The review outlined in Section 1.1.2 typically took around 90 days.*

8. If adverse findings are determined because of the quality assurance review activities, is the offeror responsible for documenting corrective action and providing corrective action monitoring?

   *Corrective action for this program has usually included additional training. We also recoup the PMPM when a core service was not provided. DSS would seek a list of trainings that might be needed for the health homes as a whole or groups of health homes related to certain concerning issues. The offeror could propose reviewing clinics with issues more closely the following year through over sampling.*

9. In section 3.2 on pg. 7, the RFP states that the offeror should confirm their ability to conduct reviews using the following methods: electronic, paper and limited in person reviews. What is the expectation for limited in person reviews? Would these be conducted onsite or in a virtual setting (e.g., WebEx/Teams/Zoom conferencing)?

   *The in-person requirement would be within the facility.*

   Are there estimates for the anticipated volume of the in-person reviews – and in which locations of South Dakota should the offeror expect to travel if in person means onsite?

   *It is anticipated that only one provider would require the vendor to meet with them in their Sioux Falls office and one person would assist the offeror to do the review for all 32 of their clinics. This provider has always required DSS to be within their facility to review their EHR. This may change, but offeror should expect to travel at a minimum to Sioux Falls.*

10. In Section 4.3, pg. 8, the RFP states an offeror may be required to submit a copy of their most recent independently audited financial statements. As a CPA firm, we do not have audited financial statements. Will internally prepared financial statements be acceptable?

    *This clause is part of our standard template. It is usually only invoked if we have concerns that the winning bidder may lack resources to finish a project. It is also sometimes invoked with RFPs where the winning bidder may be handling payments on behalf of DSS. While we do not see either one of these being the case, if for some reason we need this type of information we would work with the offeror to find an agreeable solution.*

11. Will the offeror be provided clinical information monthly or quarterly on those participants who will be included in the annual quality assurance review?

*A full year of files would be provided but they would be separated into quarters. This allows the Offeror to pull recipients from each quarter should the proposed Methodology require it.*

12. What percentage of each Tier of home health participants will be included in the annual review?

*Tier has never been included as a sample requirement. The Offeror should include the Tier as an item in the proposed methodology if they feel the Tier is important to the review.*

13. Will claims data be provided to the contractor? If so, will the contractor need to validate services provided against claims?

*Information from claims will be provided as necessary to help the offeror meet their proposed methodology. See the answer to question 24.*

14. Will the clinical information be provided mostly by electronic means or by fax?

*There is an even split between these two methods. See the answer to question 9 to see the estimated in person reviews.*

15. Will the offeror be expected to contact the health home provider and/or the participant if information is not available or complete?

*Yes – The vendor will be responsible for any follow-up required to complete the review.*

16. Since the health home provider is to provide quarterly clinical information on their participants, where will this data be stored?

*See answer to question 11.*

17. Will the offeror be able to log into the health home participant's electronic health records system to obtain the clinical information?

*That is up to the provider. Providers choosing to do electronic review have allowed us into their EHR but have always served as a tour guide for us.*

18. Cost Proposal: Should the total amount be for the three-year contract period only or should the two one-year extensions also be included?

*The Cost proposal should include an amount per year for the three-year contract period and the amount for the two one-year extensions should the State decide to exercise this option.*

19. In 1.1.2 we read the review for 2021 will encompass 137 clinics and the sample size was for the 2020 review was 446. How many clinics did the 446 samples represent?

    *There were 132 clinics included in the 2020 review.*

    Is it reasonable to assume a sample size for 2021 approximating the 446 in 2020?

    *This should be included as part of the methodology proposed. The Offeror may suggest an increase if they deem it necessary.*

20. Is it correct to assume the vendor conducts the sample selection?

    *Yes.*

21. Does each clinic have an individual EHR?

    *An EHR is a requirement of participation in the Health Home Program.*

22. Is reviewing agency verifying the service(s) selected within a quarter only or by year?

    *This should be included as part of the proposed Methodology.*

23. Can reviewing agency work with DSS on available data fields in data file or is there 1 standard export?

    *DSS currently has one standard export but would consider additional fields as proposed by the Offeror. The export currently contains. Clinic ID, Billing NPI, servicing NPI, Recipient ID, Name, DOB, Quarter core service claimed.*

24. Does reviewing agency have access to any other information other than info provided by the clinic such as the Caseload Reports portal?

    *DSS anticipates providing information about the recipients provided a core service by clinic, by quarter, a list of clinics and their clinic number and a contact for each clinic. Should the offeror feel they need more than this from DSS, please include it in the response.*

25. In section 2.0 Standard Terms and Conditions, offerors are requested to note any issues with any specific contract terms. Would such indication, if the proposed

revision is not acceptable, be cause for elimination of a response, or would there be an opportunity to discuss all considerations/issues without impact to offeror?

*These are items that would be a part of contract negotiation with the successful offeror. They would not negatively impact the selection process.*

26. Is the PMPM only paid on those HH eligible that receive a core service quarterly?

    *Yes.*

    Or who all is included in the PMPM?

    *See answer to above.*

    Also, along with the PMPM, are there are VBP or incentive measures additionally on clinical outcomes or anything else?

    *Health Homes are eligible for a Quality Incentive Payment based on the performance on their clinical outcome measures. The Offeror can learn more at https://dss.sd.gov/healthhome/paymentinformation.aspx.*

    And if so, how and who collects those VBP measures currently?

    *The clinic outcomes are a part of a contract is currently held by Health Management Associates.*

27. It is stated that there is not oversampling in the 3 big health systems because all their clinics are managed by a single individual. Is that because you are assuming some type of higher reliability or what is the rationale?

    *The assumption is that in these systems who have one individual to manage all the participating clinics, that consistent direction and training on certain items lends increased reliability to their program.*

28. 2 charts per clinic per quarter are being collected currently? (with an oversampling of 3% for those not in the big 3). What is the range of denominators across the HH clinics on average in a quarter?

    *The range of denominators per quarter using only those recipients that were provided a core service range from 1-435 recipients. This includes clinics in the big 3 systems that we did not oversample.*

29. Assuming from the current process there is no standard care management platform that is used across clinics for the HH eligible patients – please confirm.

    *Correct.*

30. And if not, are there any standards for documentation of the HH core services or information associated with the measures within the EHRs or paper charts? Meaning standards of location or types of documentation in which all HH clinics need to follow.

    *DSS did not create standards for the location of certain information. Each clinic is responsible for completing enough documentation to support that a core services was provided, and other requirements were met.*

31. In the transitions of care measures around contacts, is it "successful contacts" or any contact attempt?

    *Only "successful contacts" should be considered.*

32. When stated a "final report" – is that quarterly after each set of reviews are complete, or annually, or at the end of the 3-year contract?

    *A report should be submitted after each the review is completed annually.*

33. Are any specific disciplines (RN, RD, Social Worker, etc.) required for the Health Home reviews?

    *The offeror should state the qualifications of the staff that would conduct the review. DSS recommends a registered nurse conduct this review.*

34. How long does it usually take to complete a Health Home review?

    *This is dependent on the proficiency of the reviewer and the number of items proposed for review in the methodology.*

35. For each of the reviewed items listed in section 1.2, is there additional clarifying documentation available that details what elements are necessary to meet the requirements of each of the reviewed items?

    *Section 1.2 relates to the issuing office and RFP reference number. There is no additional documentation on the elements necessary to meet the requirements for each item.*

36. Section 3.2 mentions limited in person reviews. Will reviewer travel be reimbursed, or should the expected travel expenses be included in the proposed pricing in Attachment C?

    *Travel should be included in the cost proposal.*

37. Section 4.5 and 6.1.6 mention familiarity with the locale in which the project(s) are to be implemented. Is there a requirement for offeror's staff to be residing or located within or near the locales of the Health Homes?

    *No.*

38. Does the DSS have a preferred template or forms that should be utilized for the Final Report mentioned in section 1.1.2 and Attachment C?

    *DSS does not have a preferred template of form that should be utilized for the Final report. The Offeror should provide a report that displays the results of the review in the most effective way. The report should include both text and charts to show the results.*

39. Section 5.1.3 states the proposal should be submitted in a single PDF. Section 5.2.4 states the Cost Proposal will be evaluated independently from the technical proposal. Should the Cost Proposal be submitted in a separate PDF, or should it be included within the single PDF requested in section 5.1.3?

    *The Cost Proposal should be submitted in a separate PDF.*

40. Will the providers to be reviewed be given to the Offeror individually, or in batches?

    *Data for all providers to be reviewed will be provided at the same time.*

41. After the review begins, is there a time limit or deadline for when the Final Report must be submitted?

    *DSS would expect that results be delivered via the Final Report within 6 months after delivering the data to the Offeror.*

42. Aside from clarifying questions, is there any follow-up required once the Final Report has been submitted?

    *Offeror should make sure letters are issued to clinics prior to completing the final report and their questions are answered. After that, DSS may have some follow-up questions and then it should be considered complete.*